GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Subject: REVISED - Financial Eligibility for Institutional Care and Home and Community Based Waiver Services

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1. PURPOSE

To establish policies and procedures for determining financial eligibility for institutional care and participation in Home and Community Based Waiver programs for persons participating in these programs.

2. APPLICABILITY

This policy applies to the Department of Health Care Finance (DHCF), the Economic Security Administration (ESA), Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and HCBS Waiver Service providers.

3. AUTHORITY

The authority and functions of the DHCF as set forth in the "DHCF Establishment Act of 2007", effective February 27, 2008 (D.C. Law 17-109).

The methods for determining financial eligibility for long-term care services are established in 42 USC §§ 1396a and 1396r-5; 42 CFR §§ 435.631, 435.726, 435.821, and 435.832.

4. DEFINITIONS

Community Maintenance Needs Allowance (CMNA): The Community Maintenance Needs Allowance (CMNA) is a standard income amount that a HCBS Waiver participant living in their home may retain to afford the costs associated with living in the community, such as expenses related to mortgage, rent, food, utilities, taxes, and home repairs. The District's CMNA is the Special Income Standard (SIS) of 300% of the SSI federal benefit rate. This rate is updated annually. The CMNA is the equivalent of the Personal Needs Allowance (PNA) that is available to institutionalized individuals.

Community Spouse: A community spouse is a spouse who is not institutionalized or enrolled in a Waiver program. The term community spouse includes any spouse recognized under District law, including same-sex couples whose marriages or civil unions are recognized under the D.C. Marriage Equality Act. The term does not include registered domestic partners.

Community Spouse Allowance (CSA): The CSA is the amount of the institutionalized spouse's income that can be maintained by or transferred to the community spouse. The CSA is the amount needed to maintain or raise the community spouse's income to the Minimum Monthly Maintenance Needs Allowance (MMMNA).

Community Spouse Resource Allowance (CSRA): A CSRA is an allowance of assets that the community spouse can keep without incurring penalties.

Contribution to Cost of Care (Patient Payability Amount): The contribution to cost of care (the "patient payability amount") is the amount of money that the institutionalized or HCBS Waiver individual is responsible for paying towards their care. The contribution to cost of care is calculated based on the individual's monthly income, after allowable deductions and community spousal impoverishment income protections have been applied.

Cost of Care: The cost of care is the amount of charged by the long-term care provider or HCBS Waiver services provider(s) for long-term care or Waiver services.

Disregards: Disregards are types of income that are not taken into consideration when calculating an applicant's total countable income to determine Medicaid eligibility.

Economic Security Administration (ESA): The Department of Human Services (DHS), Economic Security Administration (ESA) determines financial eligibility for institutional care and home and community-based waiver services based upon the policies and procedures established by the Department of Health Care Finance (DHCF).

EPD Waiver Application Package: The EPD Waiver application package is the set of forms that must be submitted by the EPD Waiver case management agency to determine an EPD Waiver individual's eligibility for Medicaid coverage of EPD Waiver services.

Exempt Assets: Exempt assets are assets that are not taken into consideration when calculating an applicant's total countable assets to determine Medicaid eligibility.

Exceptional Circumstances: Exceptional circumstances are circumstances that threaten the community spouse's ability to remain in the community due to severe financial duress.

Fair Hearing: A fair hearing is an administrative hearing where individuals can appeal Medicaid eligibility decisions.

Home and Community Based Waiver (HCBS Waiver) Programs: District of Columbia Medicaid Home and Community Based Waiver (HCBS Waiver) programs are programs authorized in Section 1915(c) of the Social Security Administration Act (the Act). HCBS Waiver programs provide home and community-based services that assist Medicaid-eligible individuals to live in the community and avoid institutionalization. The District operates two HCBS Waivers: the Home and Community-Based Waiver for the Elderly and Persons with Physical Disabilities (EPD), and the Home and Community-Based Waiver for Persons with Intellectual and/or Developmental Disabilities (IDD). IDD Waiver services are available to individuals residing in their own homes and through residential supports, including Supported Living, Residential Habilitation, and Host Home.

IDD Waiver Application Package: The IDD Waiver application package is the set of forms that must be submitted by the DDS/DDA Medicaid Waiver Unit to determine an IDD Waiver individual's eligibility for Medicaid coverage of IDD Waiver services.

Income/Countable Income: All references to income in this document, unless otherwise stated, refer to countable income. Countable income includes an individual's total gross earned and unearned income, excluding income from non-countable sources detailed in Attachment A of this document.

Institutionalized Individual: An individual is institutionalized if they are receiving an institutionalized level of care in an institutional setting (i.e., nursing facility or ICF/IID). An individual in an acute care facility is considered institutionalized if they are receiving an institutionalized level of care for more than thirty (30) days, or is likely to receive an institutional level of care for more than 30 days.

Long Term Care: Long term care is health-related care and services, above the level of room and board, not available in the community that is needed regularly due to a mental or physical condition.

Marriage: The term marriage refers to all marriages recognized under District law, including common-law and same-couples whose marriages or civil unions are recognized under the D.C. Marriage Equality Act. The term does not include registered domestic partners.

Medically Needy Income Level (MNIL): For a household of two or more individuals, the Medically Needy Income Level is 50% of the annual Federal Poverty Level (FPL). For a household of one, the MNIL is 95% of the MNIL for a household of two. The MNIL is calculated annually.[1]

Medicare Covered Stay: A Medicare covered stay is the period of time in which Medicare pays for Medicare-covered long term care services. During a Medicare covered stay, Medicaid may cover an individual's Medicare cost-sharing. The amount reimbursed by Medicaid will vary based on the facility in which the individual is receiving long term care services.

Medicare Dual Eligibles: Medicare Dual Eligibles are individuals entitled to Medicare and full Medicaid benefits.

Minimum Monthly Maintenance Needs Allowance (MMMNA): MMMNA is the minimum amount of monthly income that the community spouse is entitled to possess. This may consist solely of the community spouse's income or the sum total of the community spouse's income plus the Community Spouse Allowance.[2]

Personal Needs Allowance (PNA): The Personal Needs Allowance (PNA) is a standard income amount that an individual residing in an institution or receiving residential supports through the Department on Disability Services (DDS) may retain to pay for personal needs not provided by the institution. The District's PNA is $70.00 for an individual in a nursing facility not receiving a pension from the Department of Veterans Affairs (VA), $90.00 for an individual in a nursing facility receiving a pension from the VA, and $140.00 for a couple institutionalized in a nursing facility. The PNA for individuals who receive residential supports through the Department on Disability Services (DDS), such as Supported Living, Residential Habilitation, and Host Home, is $100.00. The PNA for individuals in an ICF/IID and receive Supplemental Security Income (SSI) is $70.00. The PNA for individuals in an ICF/IID and receive Social Security Disability Income (SSDI) is $100.00. The PNA is the equivalent of the Community Maintenance Needs Allowance (CMNA) that is available to HCBS Waiver participants who live in their home.

Skilled Care: Skilled care is direct care, management, observation, and evaluation of health care provided by skilled nursing or rehabilitation staff. Skilled care includes nursing, physical therapy, occupational therapy, and speech therapy. Skilled care does not include any service that can be safely administered by a non-medical person, including one's self, without the supervision of a nurse.[3]

Special Income Standard (SIS): The Special Income Standard is 300% of the Supplemental Security Income (SSI) federal benefit rate (FBR).

[1] DC Medicaid State Plan Attachment 2.6-A, page 14; 42 CFR §435.631 and 435.831.
[2] The yearly Minimum Monthly Maintenance Needs Allowance (MMMNA) is published at cms.gov annually.
[3] Medicare.gov, *Glossary.* Available at: http://www.medicare.gov/Homehealthcompare/Resources/Glossary.aspx

Spend Down: Spend down is the process by which an individual may use medical expenses to reduce countable income to the Medicaid income limit to meet financial eligibility requirements for Medicaid coverage.

Spousal Impoverishment Protections: Spousal impoverishment protections are allowances and deductions to a couple's income and assets, defined by the Social Security Act, that are designed to prevent the impoverishment of the community spouse.[4] Spousal impoverishment protections apply to HCBS Waiver individuals and institutionalized individuals who were institutionalized in a long-term care facility on or after October 1, 1989.

Start of Care Date: The start of care date is the date on which Medicaid coverage for long-term care services begins for an institutionalized or HCBS Waiver individual.

Start of Care Packet: The start of care packet is the set of forms that must be submitted by the institutional care provider to determine an institutionalized individual's eligibility for Medicaid coverage of long-term care services. For individuals enrolled in community Medicaid, the start of care packet consists of the Long Term Care Application and Start of Care Form 1346. For individuals who are not already enrolled in Medicaid, the start of care packet must also include the Combined Application for Benefits, proof of income, proof of assets, and the Level of Care form.

5. POLICY

This document identifies policies and procedures to establish financial eligibility for long-term care services and to determine the amount a beneficiary must contribute to the cost of care for long-term care services following a determination of eligibility.

This policy also identifies requirements for the allocation of income and assets from the institutionalized spouse to a community spouse under spousal impoverishment protections.

6. PROCEDURE

I. EFFECTIVE DATES

The financial eligibility policies and procedures for Institutional and HCBS Waiver services will become effective immediately for new applicants and for current beneficiaries at renewal.

The implementation of the Spousal Impoverishment Law is effective January 1, 2014 or, if earlier than January 1, 2014, the date when the District receives approval from the Centers for Medicare and Medicaid Services (CMS) after amending its 1915(c) home and community-based services (HCBS) waiver programs (Persons with Intellectual and Development Disabilities (IDD) Waiver and the Elderly and Persons with Physical Disabilities (EPD) Waiver) to include the spousal impoverishment protections.

[4] 42 U.S.C. §1396r-5.

II. MEDICAID COVERED GROUPS

An individual in long-term care services must meet Medicaid financial and non-financial eligibility requirements in order to be eligible for Medicaid coverage of long-term care services.

NOTE: An individual must be evaluated for non-financial eligibility to receive long-term care services prior to determining financial eligibility. The level of care (LOC) documentation must be submitted to the Economic Security Administration (ESA).

There are multiple ways to financially qualify for Medicaid for long-term care services. To determine financial eligibility, the ESA must follow a two-step process:

Step 1: Decide whether the individual is financially eligible for Medicaid long-term care services. The policies and procedures for determining financial eligibility are found in Sections 6.II, III, and IV.

Step 2: If the individual is financially eligible, determine how much the individual must contribute to his or her cost of care.

NOTE: A financial eligibility determination is not required for individuals who have been determined eligible for Supplemental Security Income (SSI).

NOTE: Medicaid does not pay for long-term care services during a Medicare-covered stay in a long-term care facility. The policies and procedures for Medicare beneficiaries are found in Section 6.II.D.

A. Supplemental Security Income (SSI)

1. Policy

Individuals who have been determined eligible by the Social Security Administration (SSA) for Social Security Income (SSI) payments are categorically eligible for Medicaid and automatically financially eligible for long-term care services. SSI-eligible individuals include individuals who may be eligible for SSI, but not receiving payments.

SSI-eligible individuals, *including SSI recipients who have additional income from other sources*, are not required to complete an income eligibility determination, since such income has already been reported to and verified by SSA. There is no asset limit for SSI recipients to be eligible for Medicaid.

NOTE: SSA will terminate or adjust an institutionalized individual's

SSI payment to $30 for any full month that the individual receives institutional long-term care services.

2. Process

Determine financial eligibility for SSI-eligible individuals:

a. Verify if the individual has been determined eligible for SSI payments. If the individual is eligible for SSI payments, the individual is categorically eligible for Medicaid.

B. Special Income Standard (SIS)

1. Policy

Individuals who are over the SSI income limit should be considered for eligibility for Medicaid coverage of long-term care services under the Special Income Standard (SIS).

To be eligible for long-term care services under the SIS, the individual must have:

a. Income that does not exceed the SIS, which is 300% of the SSI federal benefit rate (FBR); and
b. Countable assets that do not exceed $4,000.

2. Process

Determine financial eligibility for individuals who are not eligible for Medicare. The policies and procedures for Medicare beneficiaries are found in Section 6.II.D:

a. If the individual is ineligible for SSI payments, determine the individual's countable income and compare it to the Special Income Standard. Refer to Section 6.III, Evaluation of Income and Assets.
b. If the individual's income is less than the Special Income Standard, determine if the individual has countable assets exceeding $4,000.
    1. If the individual has countable assets exceeding $4,000, the individual is ineligible for long–term care services coverage. The individual may choose to reallocate assets and then submit a new application for coverage. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets.

c. If the individual's countable income exceeds the Special Income Standard, the individual is ineligible for long–term care services coverage. Determine if the individual is eligible for Spend Down. Refer to Section 6.II.C, Spend Down Eligibility.
d. If the individual's countable income is at or below the SIS, the individual is financially eligible for Medicaid. The next step is to calculate the amount of the individual's contribution to the cost of care. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

3. Examples

a. *(SSI Only)* Barbara is a single adult and has been admitted into a nursing care facility. She receives only $721 per month in SSI benefits. She is categorically eligible for Medicaid coverage and automatically financially for Medicaid coverage. Her SSI payments will be reduced to $30.
b. *(SSI Plus Other Income)* Ms. Henry is applying for long-term care services and her monthly income consists of SSI in the amount of $10.00 and a pension in the amount of $700.00 a month. She is categorically eligible for Medicaid coverage and automatically financially for Medicaid coverage. Once institutionalized, her SSI payments will terminate because her additional income is greater than $30.
c. Allen is a single adult and was recently admitted to a nursing care facility. He does not have Medicare or Medicaid and his only source of income is a pension in the amount of $1,500 per month. He also has $3,500 in a savings account. Allen applies for Medicaid coverage for his long-term care. Allen is ineligible for SSI payments because his income is higher than the SSI limit. However, his income and assets are within the income and asset limits for Special Income Standard eligibility. Allen is eligible for Medicaid coverage of his long-term care services.

C. Spend Down Eligibility

1. Policy

Spend Down is the process by which individuals with medical expenses qualify for Medicaid coverage of long term care services by deducting incurred or recurring medical expenses from the individual's countable income. Refer to Attachment C - Incurred and Recurring Medical Expenses. The individual's spend down obligation is the

amount of individual's countable income that exceeds the current Medically Needy Income Level (MNIL). Refer to Section 6.III, Evaluation of Income and Assets.

Spend down for long term care services is determined for a six-month budget period. Once the individual meets the spend down obligation, the individual will be automatically enrolled in Medicaid from the first day of the month in which the individual meets the spend down obligation through the remainder of the six–month budget period. At the end of the first six month budget period, another spend down obligation will be calculated for the second six month budget period within the twelve (12) month eligibility span.

To be eligible for Spend Down, the individual must have:

a. Income that exceeds the Special Income Standard, which is 300% of the federal benefit rate (FBR); and
b. Countable assets that do not exceed $4,000.

2. Process

Determine Spend Down eligibility for individuals:

a. Verify that the individual has countable income exceeding 300% of FBR. Refer to Section 6.III, Evaluation of Income and Assets.
b. Verify that the individual does not have countable assets exceeding $4,000. Refer to Section 6.III, Evaluation of Income and Assets.
c. Calculate the individual's spend down obligation by subtracting the Medically Needy Income Level from the individual's countable income. As the individual submits documentation of payment of eligible incurred or recurring medical expenses, deduct the amount from the individual's spend down obligation. Once the individual has met the spend down obligation, enroll the individual in Medicaid coverage from first day of the month in which the individual meets their spend down obligation through the remainder of the six-month spend down budget period. Refer to Attachment C - Incurred and Recurring Medical Expenses.
d. Calculate the amount of the individual's contribution to the cost of care. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.
e. At the end of the initial six–month spend down budget period, calculate a new spend down obligation for the second six-month budget period within the individual's twelve (12) month certification period.

3. Examples

a. Wallace applies for Medicaid to cover the costs of his HCBS Waiver services. He earns $2,000 per month from his rental properties, and has additional income of $1,500 per month from his retirement pension. He does not have any assets. He does not qualify for Medicaid coverage of his long term care services because he is over the income limit for Special Income Standard eligibility. To qualify for Medicaid, he must spend down his excess income to the Medically Needy Income Level. He is over income for Medicaid coverage under the Medically Needy Income Level (MNIL) by $2,877.36 ($3,500 - $622.64). He qualifies for Spend Down and will have a spend down obligation of $17,264.16 ($2,877.36 per month x 6 months) for his six-month spend down budget period.

b. Gerald is admitted to a nursing facility following a three-month stay in Howard University Hospital's acute care unit. He does not receive Medicare benefits. He has countable assets totaling $2,000 and monthly countable income totaling $3,000. He does not qualify for Medicaid coverage of his long term care services because he is over the income limit for Special Income Standard eligibility. To qualify for Medicaid, he must spend down his excess income to the Medically Needy Income Level of $622.64. His spend down obligation is $14,264.16 ($2,377.36 per month x 6 months) for the six-month spend down budget period. He can use his medical bills from his hospital stay, his projected institutional care expenses, and any incurred medical expenses to meet his spend down obligation.

D. Qualified Medicare Beneficiaries

1. Policy

The Qualified Medicare Beneficiary (QMB) Program provides cost sharing assistance to certain low-income Medicare beneficiaries. Medicare recipients entitled to Medicare cost sharing assistance are called "Qualified Medicare Beneficiaries." Medicare beneficiaries who are entitled to full Medicaid benefits are called QMB Plus Beneficiaries. They may also be referred to as dual eligible.

Medicare will cover skilled nursing facility care costs if all of the following conditions are met:

1. The individual is eligible for Medicare Part A and has had a qualifying hospital stay of at least three (3) consecutive days of inpatient care;
2. The individual enters a skilled nursing facility within thirty (30) days of the qualifying hospital stay; and
3. The individual requires skilled care, such as skilled nursing services or physical therapy.

Medicare provides coverage for skilled nursing facility care costs for up to one hundred (100) days per Medicare benefit period, as long as the individual continues to require Medicare nursing facility skilled care services.[5]

For the first twenty (20) covered days of the Medicare benefit period, Medicare pays 100% of the cost of skilled care. For days twenty-one (21) through 100, Medicare covers 80% of the Medicare skilled nursing facility payment rate. Medicaid covers the remaining 20% of the cost sharing for QMBs and QMB Plus individuals (dual eligibles) during Medicare covered days.

NOTE: For Medicare-covered services, QMB beneficiaries including dual eligibles cannot be billed for the difference in the Medicaid and Medicare payment levels. Further, cost of care contribution requirements do not apply during days covered in any part by Medicare. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

If an individual is receiving Medicare skilled nursing facility care and is not already enrolled in Medicaid, the individual must apply for Medicaid coverage of long-term care services to receive either Medicare cost sharing assistance or full Medicaid benefits. If an individual is not eligible for Medicaid, or is only eligible for Medicare cost sharing assistance as a QMB, the individual will become financially responsible for the cost of his or her care if they remain in the nursing facility after Medicare coverage ends. Refer to Section 7, Responsibilities of Long-Term Care Providers and the Economic Security Administration (ESA).

a. *Qualified Medicare Beneficiary (QMB)* – The Qualified Medicare Beneficiary program (QMB) provides Medicaid

[5]An individual's Medicare benefit period begins when the person enters the hospital or skilled nursing facility and ends when either: the individual has not been in either a skilled nursing facility or hospital for at least 60 days in a row; or the individual remains in a skilled nursing facility but has not received skilled care there for at least 60 days in a row. *See* Centers for Medicare and Medicaid Services. *Medicaid Coverage of Skilled Nursing Facility Care*, 14. http://www.medicare.gov/publications/pubs/pdf/10153.pdf.

coverage of the beneficiary's Medicare cost sharing, including the 20% of the cost of skilled care during Medicare covered days 21 through 100.

To be eligible for QMB, the individual must have:

i. Income at or below 300% of the Federal Poverty Level (FPL)
ii. There is no asset limit for the QMB program

b. *QMB Plus* – QMB Plus provides full Medicaid benefits and Medicaid coverage of the beneficiary's Medicare premiums and cost sharing. QMB Plus beneficiaries must meet financial eligibility for Medicaid.

To be eligible for QMB Plus, the individual must have:

i. Countable income below 100% of the FPL; and
ii. Countable assets below $4,000

c. *Spend Down Dual Eligible* – Spend down dual eligibles are eligible for coverage of the Medicare Part B premium and Medicare cost sharing.

Medicare recipients who have income exceeding the QMB income limit (300% of the FPL) may spend down to the Medicaid Medically Needy Income Level (MNIL) for Medicaid eligibility. Refer to Section 6.II.C, Spend Down Eligibility.

2. Process

To determine if an individual entitled to Medicare Part A is eligible for QMB assistance:

a. Determine the individual's countable income. Refer to Section 6.III, Evaluation of Income and Assets.
b. Compare the individual's countable income to the QMB level. If the individual has countable income under 300% of FPL, the individual is eligible for Medicaid coverage of the individual's Medicare cost-sharing under QMB.
c. Verify whether the individual is eligible for Medicare coverage for long–term care services. If the individual is not eligible for Medicare coverage, compare the individual's countable income to the QMB Plus and Special Income Standard levels. Refer to Section 6.II.B, Special Income Standard (SIS). Verify that the individual does not have countable assets exceeding $4,000. Refer to Section 6.III,

Evaluation of Income and Assets.

1. If the individual has countable assets exceeding $4,000, the individual is ineligible for long–term care services coverage. The individual may choose to reallocate assets and then submit a new application for coverage. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets.
2. If the individual has countable income under 100% of FPL, the individual is eligible for full Medicaid benefits under QMB Plus.
3. If the individual has countable income between 100% of FPL and 300% of FPL, the individual is eligible for Medicaid coverage of long–term care services only under the Special Income Standard.
4. If the individual's countable income exceeds 300% of FPL, the individual is ineligible for long–term care services coverage. Determine if the individual is eligible for Spend Down. Refer to Section 6.II.C, Spend Down Eligibility.

d. Calculate the amount of the individual's contribution to the cost of care during non-Medicare covered days. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

3. Examples

e. Devon receives $2,500 per month in SSDI benefits and is enrolled in Medicare Part A. She has $1,000 in a checking account. She is admitted into a nursing care facility. The nursing facility submits a QMB application on Devon's behalf to cover her Medicare cost-sharing. She is eligible for QMB cost-sharing because her income is under 300% of FPL. For the first twenty (20) she receives skilled care services, her Medicare Part A will cover 100% of her costs. Medicaid will cover her Medicare cost-sharing. After 23 days, she stops receiving skilled care services and her Medicare coverage ends. Her nursing facility submits a new application for Medicaid coverage of her long-term care services. She is over the Special Income Standard limit of 300% of SSI FBR. She has the option to spend down to the Medicaid Medically Needy Income Level (MNIL) for Medicaid eligibility.

f. Franz is a Medicare eligible individual who was admitted to a nursing care facility. Franz applies for Medicaid coverage for his long-term care. He has $900 per month in income. He is under the income limits for QMB and QMB Plus. He

is eligible for QMB coverage of his Medicare cost-sharing during his Medicare covered days and full Medicaid benefits when his Medicare coverage ends.

III. EVALUATION OF INCOME AND ASSETS

The Economic Security Administration (ESA) will evaluate the income and assets of the individual applying for or receiving institutional or Waiver services to determine whether the individual is financially eligible to receive Medicaid long-term care services. The income and asset evaluation will be used to establish initial financial eligibility and the individual's continuing contribution to the cost of his or her care.

ESA will count only the income and assets available to the individual at the time of the initial eligibility determination. If the individual has a community spouse, ESA will also evaluate the community spouse's income and assets to determine whether the institutionalized or Waiver spouse may lower his or her contribution to the cost of care to provide financial support to the community spouse. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

A. Policy

i. Income

Gross countable income is used to determine financial eligibility for long-term care coverage. Gross countable income includes any income from countable income sources. Income from non-countable income sources is excluded from the individual's gross countable income. Countable and non-countable income is defined in Attachment A - Income.

Income limits for specific coverage groups, if applicable, are defined in Section II.

1. **Allocation of community spouse's income to institutionalized or Waiver spouse**

   If the payment of income is made solely in the name of the community spouse, no income of the community spouse shall be deemed available to the institutionalized or Waiver spouse during any month following the month of application in which the spouse receives institutional or Waiver long-term care services.

   NOTE: If payment of income is made in the names of both spouses, the income shall be allocated as follows:

   a. If the income does not come from a written legal document ("instrument") that establishes the ownership of the income, such as a trust, then one-half of the income shall be

considered available to each spouse.

b. If an instrument or trust document allocates the income, the income shall be considered available in accordance with the instrument allocation.[6]
   i. If payment of income is made solely in the name of one spouse, the income shall be considered available only to that spouse.[7]
   ii. If payment of income is made in the names of both spouses, one-half of the income shall be considered available to each.[8]
   iii. If payment of income is made in the names of (1) the institutionalized or Waiver spouse, the community spouse, and another person(s); (2) the institutionalized or Waiver spouse and another person(s); or (3) the community spouse and another person(s), the income shall be considered available to each spouse in the proportion to the spouse's interest.[9] If payment is made to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.[10]

2. **Rebuttal of income determination rules**

Income determination rules can be rebutted if the institutionalized or Waiver spouse can establish, by a preponderance of the evidence during a fair hearing, that the ownership interest in a source of income should not be assigned as described above.

3. **Periodic reconciliation of income**

At the end of each six-month period, or whenever any significant change in the institutionalized or Waiver individual's income or circumstances occurs, the District must reconcile projected income with the actual income that was received. The reconciliation may be made for a period up to six months prior to the month the reconciliation is done.

ii. **Assets**

[6] 42 U.S.C. 1396r-5(2) (A); 42 U.S.C. 1396r-5(b) (2) (B) (ii).
[7] 42 U.S.C. 1396r-5(b) (2) (A) (i); 42 U.S.C. 1396r-5(b) (2) (B) (I).
[8] 42 U.S.C. 1396r-5(b) (2) (A) (ii); 42 U.S.C. 1396r-5(b) (2) (B) (II).
[9] 42 U.S.C. 1396r-5(b) (2) (A) (iii); 42 U.S.C. 1396r-5(b) (2) (III).
[10] Id.

All countable assets are counted to determine financial eligibility for long–term care coverage. Exempt categories of assets, such as the individual's home or vehicle, are not included in the individual's countable assets. Exempt assets are defined in Attachment B – Assets.

Asset limits for specific coverage groups, if applicable, are defined in Section II. If an asset determination is required for financial eligibility, countable assets must be under $4,000 for individuals and $6,000 for couples on any day of the month for which eligibility is determined.

NOTE: Individuals institutionalized in a long-term care facility for longer than six (6) months will have a lien placed on their home, unless there is community spouse or dependent residing in the home. This rule does not apply to individuals receiving HCBS Waiver services.

1. **Spousal share for married couples**

   One-half of the couple's total countable assets are considered available to the institutionalized or Waiver spouse. Any assets held by either spouse at the time of long-term care placement in an institution or Waiver program are counted in the spousal share.

2. **Allocation of assets for married couples**

   All assets held by the institutionalized or Waiver spouse, the community spouse, or both, shall be considered available to the institutionalized or Waiver spouse, unless one of the following exceptions apply:

   a. The institutionalized or Waiver spouse has assigned to the District any rights to support from the community spouse;
   b. The institutionalized or Waiver spouse lacks the ability to execute an assignment due to physical or mental impairment, but the District has a right to bring a support proceeding against a community spouse without such assignment; or
   c. The District determines that the denial of eligibility would work an undue hardship. Refer to Section 6.III.E.iv, Undue Hardship Waiver of Penalty Period.

3. **Treatment of spousal assets during the continuing eligibility period**

   The community spouse's assets are only counted for the month of application.

4. **Reallocation of excess countable assets**

   If countable assets exceed the applicable asset limit, the individual may be able to reduce countable assets by reallocating them from countable to non-countable sources.

B. Process

Determine countable income for individuals and married couples:

i. Add all income from countable income sources. Do not include non-countable income. Refer to Attachment A – Income.
ii. If an institutionalized or Waiver spouse receives income pursuant to an instrument or trust document, add that income to the countable income pursuant to the terms of the instrument or Refer to Section 6.III.A.i.1, Allocation of community spouse's income to institutionalized or Waiver spouse.
iii. Reconcile the individual's countable income at the end of each six-month period or if the individual reports a change in income. Refer to Section 6.III.A.i.3, Periodic reconciliation of income.

Determine countable assets for individuals and married couples:

iv. Add all assets available to the individual. If the individual is married, include all assets available to the spouse, unless an exception applies. Refer to Section 6.III.A.ii.2, Allocation of assets for married couples. Do not include exempt assets. Refer to Attachment B – Assets.
v. If the individual is married, determine the spousal share. Reduce the total combined countable assets available to each spouse by one-half.
vi. If the individual is over the asset limit for the applicable coverage group, the individual is ineligible for long-term care services coverage. The individual may choose to reallocate assets and then submit a new application for coverage. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets.

C. Examples

i. Gerald applies for a HCBS Waiver program. He does not receive Medicare benefits. He has countable assets totaling $5,000 and monthly countable income totaling $3,000. He does not qualify for Medicaid coverage of his HCBS services because he is over the income limits for Special Income Standard eligibility. He is also over the asset limit for Medicaid. To be able to spend down his income to the Medically Needy Income Level, Gerald must first reduce his countable assets by reallocating them from countable to non-countable sources. Gerald

purchases a burial plot for $1,100, bringing his total countable assets down to $3,900. He can now submit a new application for coverage and will be determined to meet the asset limit and eligible to spend down his excess countable income to the Medically Needy Income Level.

ii. Paul is a married man residing in a nursing facility. He has countable assets totaling $3,000, monthly income in his name of $2,000, and an additional income source of $1,500, which is in the name of both him and his spouse. For the purposes of spend down, his total countable income is all of the income in his name, plus one half of all income he shares with his spouse. His total countable income is $2,750 per month.

iii. Roopa, an institutionalized spouse, and Anthony, her community spouse, each own a one-half interest in a trust that pays $200 per month. The income is attributed to them in proportion with their interest. Therefore, $100 is attributed to Roopa and $100 is attributed to Anthony.

iv. Robert, an institutionalized spouse, owns a trust that is entirely in his name. The trust provides $300 in income each month. The entire $300 is attributed to him. He and his spouse, Sally, were foster parents before entering the institution. As foster parents, they received $600 per month in foster care payments. While Robert is institutionalized, the foster care payments that Sally receives are not deemed available to him.

D. Right to Request a Resource Assessment

The institutionalized or Waiver individual or a community spouse has the right to request a resource assessment at the beginning of the first continuous period of institutionalization. If a resource assessment request is made, the District will calculate and document the total value of the individual's or couple's assets. The District must retain a copy of the resource assessment and also provide a copy to the individual or spouse. The District must also notify the individual or spouse of their right to a fair hearing on the resource assessment.[11]

E. Penalty Period for Improper Transfer of Assets

i. Policy

When an individual applies for Medicaid coverage for institutional or HCBS Waiver long-term care services, the individual will be subject to a review, or "look back," to determine whether the individual or his or her spouse transferred assets to another person or party for less than fair market value (FMV). The look back period consists of the sixty (60) months prior to the date the individual applied for Medicaid. When individuals transfer assets at less than FMV, they are subject to a penalty that delays the date they can qualify to receive Medicaid long term care services.[12] Refer to Attachment D – Treatment of Trusts, Annuities, and

[11] 42 U.S.C. 1396r-5(c)(1)(B).

[12] Deficit Reduction Act of 2005 §6011; DC Medicaid State Plan, Supplement 9(a) to Attachment 2.6-A.

Certain Financial Transactions.

NOTE: If an individual's right to receive income or assets is given or assigned in some manner to another person, such a gift or assignment is treated as a transfer of assets for less than fair market value.

NOTE: The transfer of lump sum payments before they can be counted as assets is treated as a transfer of assets for less than fair market value.

NOTE: For jointly owned assets, a withdrawal of funds or removal of the asset by the other owner that removes the funds or property from the control of the individual is treated as a transfer of assets for less than fair market value. The placement of another person's name on the account or asset that limits the individual's right to sell or dispose of the asset is treated as a transfer of assets for less than fair market value.

ii. Exceptions to Penalty Period for Improper Transfer of Assets

The following transfer of assets shall not be subject to a penalty:

1. The asset transferred is the individual's home, and title to the home is transferred to:
    a. The spouse of the individual;
    b. A child of the individual who is under age 21;
    c. A child who is blind or permanently and totally disabled;
    d. The sibling of the individual who has an equity interest in the home and who has been residing in the home for a period of at least one year immediately before the date the individual becomes institutionalized; or
    e. A son or daughter of the individual (other than a child as described above) who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.

2. The assets:
    a. Were transferred to the individual's spouse or to another for the sole benefit of the spouse;
    b. Were transferred from the individual's spouse to another for the sole benefit of the spouse;
    c. Were transferred to the individual's child who is blind or permanently and totally disabled, or to a trust established solely for the benefit of the individual's child;
    d. Were transferred to a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined under SSI.

3. A satisfactory showing is made to the District that:
    a. The assets have been returned to the individual or the fair market equivalent has been returned;
    b. The assets were transferred only for a reason other than to qualify for Medicaid long term care services; or
    c. The individual intended to dispose of the assets for fair market value.

iii. **Undue Hardship Waiver of Penalty Period**

The penalty period may be waived if doing so could create an undue hardship. Undue hardship may exist if:

1. The individual has been threatened with eviction from a long-term care facility or medical institution and has exhausted all legal methods to prevent the eviction; or
2. The individual's HCBS Waiver provider has threatened to terminate HCBS Waiver services; and
    i. The transferee is no longer in possession of the transferred asset and the transferee has no other assets of comparable value with which to pay the cost of care; and
    ii. There is no family member or other individual or organization able and willing to provide care to the individual; or
3. The individual would be deprived of medical care that would endanger his or her life or health; or food, clothing, shelter, or other necessities of life; or
4. Any other undue hardship or good cause exemption exists, as may be defined by the Secretary for the Department of Health and Human Services or the Secretary for the Department of Agriculture. [13]

iv. **Process**

An asset is considered to be transferred for less than fair market value (FMV) if the asset was given away or if the amount received by the individual for the asset is less than its fair price in the local market.

To determine the penalty period, ESA will divide the total uncompensated value of the transferred asset by the average monthly cost of a private pay nursing facility patient in the District. The total uncompensated value is determined by subtracting the amount received by the individual from the FMV of the asset. If the calculation results in a partial month at the end of the penalty period, the individual is only eligible for long-term care services for the portion of the month after the penalty period ends.

[13] DC Medicaid State Plan, Supplement 9(a) to Attachment 2.6-A, page 5.

v. Examples

1. Elaine, an institutionalized spouse, transfers her $20,000 bank account to her community spouse, Jane. The transfer is legal because Jane is her community spouse. Elaine will not be penalized for making this transfer. If Elaine transferred her bank account to her daughter, Carla, instead of Jane, she would be subject to a penalty period because Carla is not her community spouse.
2. Bridget, an institutionalized spouse, transferred her $20,000 bank account to her daughter six years ago. This transfer will not subject Bridget to a penalty period because this transfer occurred outside of the look back period.
3. Sam sold his vacation home to his neighbor two months before he was admitted to a nursing care facility. The neighbor paid him $30,000 even though the value of the home was $100,000. The uncompensated value of the home is $70,000. Because the improper transfer occurred within the 60 month look back period, he will be assessed a penalty period. If the average monthly cost of nursing facility care in the District $7,000, he will not be eligible for Medicaid coverage of long-term care services for the first ten (10) months he is institutionalized ($70,000 divided by $7,000 equals 10).

IV. COMMUNITY SPOUSAL IMPOVERISHMENT PROTECTIONS

The Medicaid program creates financial protections for the spouses of individuals who require institutional or HCBS Waiver services. Spousal impoverishment protections are allowances and deductions to a couple's income and assets, defined by the Social Security Act, that are designed to prevent the impoverishment of the community spouse.[14] Currently, spousal impoverishment protections apply only to institutionalized spouses who were institutionalized in a long-term care facility on or after October 1, 1989. Under the 2010 Spousal Impoverishment Law, implemented under the Medicare Catastrophic Coverage Act of 1988 (MCCA), spousal impoverishment protections were extended to the spouses of HCBS Waiver individuals from January 1, 2014. Spousal impoverishment protections are not afforded to an individual who becomes eligible through the spend down process until the full amount of the spend down obligation is met.

A. Community Spouse Allowance (CSA)

[14] 42 U.S.C. §1924(d)(3), (6); Medicaid State Plan, Supplement 13 to Attachment 2.6-A.

i. **Policy**

The community spouse of an institutionalized or Waiver individual may retain a minimum monthly maintenance needs allowance (MMMNA), plus any excess shelter allowance, if applicable.[15] Excess shelter allowances may include rent or mortgage payments, electric, gas, heating oil, water, and a standard telephone deduction.

If the community spouse's countable income is less than the MMMNA, the institutionalized or Waiver spouse may provide the difference between the MMMNA and the community spouse's income. If the institutionalized spouse does not have income sufficient to bring the community spouse's monthly income allowance up to the MMMNA, the institutionalized or Waiver spouse may transfer any available assets that can produce income up to meet the MMMNA.[16] If the institutionalized or Waiver spouse does not have sufficient income or income producing assets to bring the community spouse's income up to the MMMNA, the community spouse will not receive the MMMNA.

The institutionalized or Waiver individual may deduct the amount provided as a spousal allowance from the institutionalized or Waiver spouse's countable income as long as the allowance is made available to the community spouse.

NOTE: The District shall verify that the individual has actually made available any spousal allowance to the community spouse at the first regularly scheduled renewal following the initial eligibility determination.

ii. **Process**

1. Determine the amount of countable income available to the community spouse. Refer to Section 6.III, Evaluation of Income and Assets.
2. Determine the total MMMNA the community spouse is entitled to receive by adding any excess shelter expenses to the MMMNA.
3. If the community spouse's countable income is less than the total MMMNA, verify the amount of the institutionalized or Waiver spouse's countable income. Refer to Section 6.III, Evaluation of Income and Assets.
    a. Deduct this amount from the institutionalized or Waiver spouse's countable income.
    b. If there is still an income deficit, verify the institutionalized or Waiver spouse's countable assets and the institutionalized or Waiver spouse to transfer to the

[15] This amount is published annually by CMS on cms.gov.
[16] 42 U.S.C. §1924(a).

community spouse the amount of assets needed to produce the amount of income to meet the MMMNA. Refer to Section 6.III, Evaluation of Income and Assets.

c. If there is still is an income deficit, the community spouse will not receive the MMMNA.

iii. **Exception: Allowance Greater than the MMMNA**

The community spouse may be entitled to a monthly amount higher than the MMMNA if he or she has a court order for spousal support or demonstrates "exceptional circumstances resulting in severe financial duress." Exceptional circumstances may include: recurring or extraordinary non-covered medical expenses; amounts to preserve, maintain, or make major repairs to a home; transportation costs; and amounts necessary to preserve an income-producing asset.

Exceptional circumstances must be determined at a fair hearing within thirty (30) days of the request for hearing.

iv. **Examples**

1. Ann is a community spouse whose income is $2,500 per month. Ann's income is $561.25 less than the MMMNA of $1,938.75. Her spouse, Ted, has income of $900 per month. Ted may transfer $561.25, the difference between the MMMNA and Ann's income, to her in order to bring her income up to $1,938.75. Ted may deduct the $561.25 from his countable income under the community spouse allowance. Ted's countable income is $338.75.
2. If Ann also pays $75 for gas, $120 for electric, $21 for telephone, and $50 for water each month, she will be entitled to retain the total amount, $266, in addition to the MMMNA under the excess shelter allowance. Ted may also deduct $266 from his countable income under the community spouse allowance. Ted's countable income is now $72.75.
3. Laura is a community spouse whose income is $500 per month. Her spouse, Mary, resides in a nursing facility. Her income is $1,438.75 less than the MMMNA of $1,938.75. The total amount that Mary is allowed to transfer to Laura is $1,438.75, the difference between Laura's income and the MMMNA. However, Mary only has $600 per month in income, which only brings Laura's income to $1,100. If Mary has assets in her own name, she can transfer the amount of assets necessary to produce the $838.75 each month to Laura to meet the MMMNA. In order to make such transfer, either Laura or Mary must establish at a fair hearing that the community spouse resource allowance is inadequate to raise he community spouse's income up to the

MMMNA. If so, Mary may transfer assets to Laura to generate $838.75 each month, bringing Laura's total income up to the MMMNA.

B. Community Spouse Resource Allowance (CSRA)

i. Policy

A community spouse may retain a portion of the couple's shared assets to meet current and future financial needs. The Centers for Medicaid and Medicare Services (CMS) sets the minimum and maximum amounts that may be claimed by a community spouse as a community spouse resource allowance (CSRA).

The CSRA is the spousal share of assets available to the community spouse during the initial eligibility determination, unless the spousal share is less than or greater than the resource standards set by CMS. If the spousal share is lower than the CMS minimum resource standard, the community spouse may claim the minimum resource standard. If the spousal share is greater than the CMS maximum resource standard, then the community spouse may only claim the maximum amount.[17]

1. Transfers of Assets to Community Spouse

An institutionalized or Waiver spouse may, without regard to penalties for transfers of assets for less than fair market value, transfer assets to the community spouse in an amount up to the community spouse resource allowance. This transfer shall be made as soon as possible after the determination of eligibility, taking into account the time needed to obtain a court order for support, if applicable.

If a court has ordered the institutionalized or Waiver spouse to support the community spouse, the penalty process shall not apply to assets transferred pursuant to such order for the support of the spouse or a family member.

NOTE: The District shall verify that the institutionalized spouse has completed any required asset transfers at the first regularly scheduled renewal following the initial eligibility determination.

2. Exception: Increased CSRA

If either the community spouse or the institutionalized or Waiver spouse is dissatisfied with the CSRA determination, that spouse is

[17] 42 U.S.C. §1924(f)(2).

entitled to a fair hearing within 30 days of the request for hearing. If either spouse establishes at the fair hearing that the CSRA does not generate enough income to raise the community spouse's income to the Minimum Monthly Maintenance Needs Allowance (MMMNA), the community spouse resource allowance shall be increased to an amount adequate to provide the MMMNA.

The amount of the CSRA may also be set by a court order or fair hearing, in such case the minimum and maximum amounts are not controlling.

ii. **Process**

1. Determine the couples' combined countable resources and the spousal share. Refer to Section 6.III.A.ii.1, Spousal share for married couples.
2. Compare the community spouse's spousal share to the CMS resource standards to determine the couple's protected asset amount. If there is a court order or amount set by fair hearing, then do not compare this amount to the CMS resource standards. If the spousal share is over the maximum standard, set the CSRA at the maximum amount. If the spousal share is under the minimum standard, set the CSRA at the minimum amount. Otherwise, set the CSRA at the spousal share.
3. If the community spouse's countable assets are lower than the CSRA, allow the institutionalized or Waiver spouse to transfer assets to the community spouse up to the CSRA.
4. If the CSRA does not generate enough income to raise the community spouse's income to the MMMNA, notify the individual that either spouse may request a fair hearing to increase the CSRA.
5. Compare institutionalized spouse's unprotected spousal share to the asset limit for one person ($4,000). If the unprotected spousal share exceeds the asset limit, the couple is not eligible for Medicaid long term care services. Allow the individual to reduce unprotected assets to the asset limit.

iii. **Examples**

1. Mary is a community spouse. Her spouse, James, is institutionalized. The couples' total countable assets are $110,000. The spousal share, which is one-half the couple's total countable assets in either or both Mary's and James's names at the time of institutionalization, is $55,000. The amount of the spousal share is greater than the minimum and less than the maximum, so the CSRA is the amount of the spousal share: $55,000. Mary may keep $55,000 in assets without incurring any penalties. The

remaining $55,000 is the unprotected asset amount used to determine James's eligibility. Because $55,000 is greater than the assets limit for one person ($4,000), Mary and James would need to reduce the unprotected assets of $55,000 down to $4,000 before Medicaid would begin to help pay for institutional care.

2. John is a community spouse. His spouse, Jerry, is institutionalized. The couples' total countable assets are $30,000. The spousal share, which is one-half of the couple's total countable assets held by either or both of them, is $15,000. The amount of the spousal share is less than the minimal CSRA of $23,448. Therefore, John may keep a CSRA of $23,448. Jerry's remaining assets are $6,552 ($30,000 minus $23,448) which is over the asset limit for one person ($4,000) by $2,552. John and Jerry would need to reduce Jerry's remaining assets to the asset limit before Medicaid would begin to help pay for Jerry's care.
3. Charles is a community spouse. His spouse, Julie, is institutionalized. The couple's total combined assets are $110,000. The spousal share, which is one-half of the couple's total countable assets held by either or both of them, is $55,000. This amount is greater than the minimum of $23,448, but less than the maximum CSRA of $117,240 so in this case, Charles may keep the CSRA of $55,000 without incurring any penalties. However, Charles is dissatisfied with the amount of the CSRA, so he requests a fair hearing. During the hearing, the Administrative Law Judge establishes $65,000 as a CSRA for Charles. Julie needs to transfer an additional $10,000 from her countable assets to Charles to bring his CSRA up to $65,000. Charles and Julie would then need to reduce Julie's remaining assets of $45,000 down to $4,000 before Medicaid would begin to help pay for her care.

C. Rights to a Fair Hearing under the Spousal Impoverishment Law for Assets and Income

When an institutionalized or Waiver spouse has applied for Medicaid coverage of long-term care services, either the community spouse or the institutionalized or Waiver spouse may request a fair hearing on any of the following:

1. The Community Spouse Allowance;
2. The amount of any other income otherwise determined available to the community spouse;
3. The Spousal Share;
4. The Community Spouse Resource Allowance; or
5. The attribution of assets.

Any such hearing respecting the determination of the community spouse allowance or community spouse resource allowance shall be held within 30 days of the request for the hearing.

V. CALCULATION OF BENEFICIARY CONTRIBUTION TO THE COST OF CARE (PATIENT PAYABILITY AMOUNT)

A. Policy

After an institutionalized or Waiver individual has been determined eligible for Medicaid coverage of long-term care services, the Economic Security Administration (ESA) will calculate the amount the institutionalized or Waiver individual is obligated to contribute to the cost of his or her care. The Medicaid program must reduce its payment for institutional care or HCBS Waiver services to the long-term care provider by the amount of the eligible individual's monthly income, after allowable deductions and community spousal impoverishment income protections have been applied. The amount left constitutes the beneficiary's contribution to cost of care.

The definition of income is the same as is used in the eligibility determination process. Refer to Section 6.III, Evaluation of Income and Assets.

i. **Allowable Deductions from Income**

1. **Personal Needs Allowance (for Institutionalized Individuals Only)** - The Personal Needs Allowance (PNA) is a standard income amount that an individual residing in an institution or receiving residential supports through the Department on Disability Services (DDS) may retain to pay for personal needs not provided by the institution. The District's PNA is $70.00 for an individual in a nursing facility and $140.00 for a couple institutionalized in a nursing facility. For an individual in a nursing facility who receives a VA pension, the PNA is $90.00. The PNA for individuals who receive residential supports through the Department on Disability Services (DDS), such as Supported Living, Residential Habilitation, and Host Home, is $100.00. The PNA for individuals in an ICF/IID who receive Supplemental Security Income (SSI) is $70.00. The PNA for individuals in an ICF/IID who receive Social Security Disability Income (SSDI) is $100.00. The PNA is the equivalent of the Community Maintenance Needs Allowance (CMNA) that is available to HCBS Waiver participants who live in their home.

2. **Community Maintenance Needs Allowance (CMNA):** the Community Maintenance Needs Allowance (CMNA) is a standard income amount that an HCBS Waiver participant living in their

home may retain to afford the costs associated with living in the community, such as expenses related to mortgage, rent, food, utilities, taxes, and home repairs. The District's CMNA is the equivalent of the Special Income Standard (SIS), or 300% of the SSI federal benefit rate. The CMNA is the equivalent of the Personal Needs Allowance (PNA), but applies to Home and Community-Based Waiver participants who live in their home.

3. **Community Spouse Allowance** - The institutionalized or HCBS Waiver individual may deduct the Community Spouse Allowance from the institutionalized or Waiver individual's countable income, as long as the allowance is made available to the community spouse. Refer to Section 6.III.A.ii.2, Allocation of assets for married couples.

4. **Dependent Family Allowance** - An institutionalized or HCBS Waiver individual may deduct an amount for the financial maintenance of other family members living in the home. The term "family member" includes only: minor or dependent children, including adult children with a disability, dependent parents, or dependent siblings of the institutionalized or community spouse who reside with the community spouse.

   The Dependent Family Allowance is the equivalent of the Medically Needy Income Level (MNIL) for each dependent family member.

5. **Other Incurred Medical or Remedial Care Expenses** - An institutionalized or HCBS Waiver individual may have medical expenses that are not covered by Medicaid or other third-party insurance, such as health insurance premiums, pre-eligibility medical expenses (PEME) which were incurred but not paid, deductibles, copays and guardianship/conservator costs. If medical expenses are used to meet a spend down amount, they may also be used as a medical expense in post eligibility.
   a. Guardianship/ Conservator Costs
      i. Remedial expenses can include fees paid to a guardian, conservator, or representative payee. A guardian or conservator is appointed when an individual lacks the capacity to care for him or herself or to manage his/her medical, legal, and financial affairs.
      ii. Guardianship or conservator fees include but are not limited to:
         1. Court filing fees;

2. Court-approved guardianship/conservatorship fees; and,
3. Court-approved legal fees.

iii. The individual must submit a copy of the court order or other legal agreement, and any supporting documentation, including an itemized bill for allowable guardianship/conservatorship expenses.

6. **Home Maintenance Deduction (for Institutionalized Individuals Only) -** If the individual has no community spouse living at home, and a physician has certified that the institutionalized individual is likely to return home within six (6) months, an amount may be deducted for the maintenance of the home.

   The home maintenance deduction is equal to the MNIL for one individual, and must not be deducted for more than a six (6) month period.

7. **Supplemental Security Income (SSI) or State Supplementary Payment (SSP) Benefits -** If the institutionalized or HCBS Waiver individual receives Supplemental Security Income (SSI) or State Supplementary Payment (SSP) benefits, the individual may deduct the full amount of these benefits.

ii. **Process**

Calculate the institutionalized or Waiver individual's contribution to his or her cost of long-term care services; after an individual has been determined eligible for Medicaid coverage of long-term care services:

1. Calculate the individual's countable income. Refer to Section 6.III, Evaluation of Income and Assets.
2. Subtract all applicable deductions from the individual's countable income. The remaining countable income is the patient payability amount.
3. Certify the patient payability amount for a one-year period. Notify the institutional or Waiver provider(s) and the individual of the patient payability amount.
4. At the end of each six-month period, or whenever any significant change in the individual's income or circumstances occurs, reconcile the projected income with the actual income that was received. Refer to Section 6.III.A.i.3, Periodic reconciliation of income. If a change in income is found at the time of reconciliation, recalculate the individual's patient pay amount and issue a new Form 1445. Any adjustments to the individual's patient pay amount will be applied prospectively.

iii. Examples

1. *(SSI Only)* - Ms. Jones resides in a long-term care facility and is applying for Medicaid coverage. Her monthly income is the amount she receives as an SSI beneficiary, which is $70.00 per month. Ms. Jones' SSI will reduce to $30.00 and the District would give her a state supplement in the amount of $40.00, to make her monthly income $70.00. Her personal need allowance in the long-term care facility would be $70.00. Her patient payability will be deducted from her monthly income (70 minus 70), which makes her patient payability equal zero.
2. *(SSI Plus Other Income)* - Ms. Henry resides in a long-term care facility and is applying for Medicaid. Her monthly income consists of SSI in the amount of $10.00 and a pension in the amount of $700.00 a month. Her SSI payments will terminate because her additional income is greater than $30. If Ms. Henry has incurred medical expenses of $30, her patient payability will be $600 ($700 minus $70 for her PNA and $30 for her incurred medical expenses deduction).
3. Mary received long term care services through an HCBS Waiver for the past two years. Mary has earned income from a part time job. She has worked three days a week during the past six months, earning $1,000 per month. In future months, Mary will work only two days a week, earning $700 per month. The District will treat Mary's average earnings ($1,000) as monthly income for the next six months. At the end of the six months, the District will determine Mary's actual income to reconcile any discrepancies between her projected income ($1,000) and actual income ($700). The District will use Mary's actual income as her projected income for the next prospective six month period.

7. TREATMENT OF INCOME AND ASSETS DURING ELIGIBILITY PERIOD AND AT ANNUAL RENEWAL

I. VERIFICATION OF ALLOWABLE TRANSFER OF ASSETS

Where an institutionalized individual is allowed to transfer excess countable assets following the initial eligibility determination to a community spouse, the individual must reallocate excess countable assets as soon as practicable before the first regularly scheduled renewal. No reallocation of assets to the community spouse may be made after the first annual renewal. Refer to Section 6.III, Evaluation of Income and Assets.

The District shall verify that the individual has transferred excess countable assets and/or

made available any amount of income under a spousal allowance to the community spouse at the first annual renewal following the initial eligibility determination. If excess countable assets have not been transferred and/or income has not been made available by the first annual renewal, the assets and/or income will be counted against the beneficiary spouse and may result in termination of long term care benefits.

Example:

1. Florence is a community spouse. Her spouse, Benjamin, is institutionalized. The couples' total countable assets are $24,000. The spousal share, which is one-half of the couple's total countable assets held by either or both of them, is $12,000. The amount of the spousal share is less than the minimum resource standard of $23,448. Therefore, Florence may keep a Community Spouse Resource Allowance (CSRA) of $23,448. At Benjamin's first annual renewal, the District will verify that any assets that were above the $4,000 asset limit were transferred from Benjamin's name into Florence's name.

II. CHANGES IN INCOME OR ASSETS DURING ELIGIBILITY PERIOD

A community spouse's income and assets are not deemed to be available to the institutionalized spouse for any month following the month of application. When there are changes in the amount of a community spouse's income or assets following the initial eligibility determination, no changes in the amount of the Community Spouse Allowance (CSA) or Community Spouse Resource Allowance (CSRA) will be made until the first annual renewal. When an institutionalized spouse receives an increase in countable income or assets, the District shall re-determine financial eligibility for the institutionalized spouse. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets and Section 6.IV.B.i.1, Transfer of Assets to Community Spouse.

Example:

1. Betty, an institutionalized spouse, and Alfred, her community spouse, each own a one-half interest in a trust that pays $200 per month. The income is attributed to them in proportion with their interest. Therefore, $100 is attributed to Roopa and $100 is attributed to Alfred. During the eligibility period, Alfred begins receiving pension payments of $3,000 per month and a lump sum payment of $10,000. These amounts will not be considered available to Betty at any point during the eligibility period. At renewal, the amount of any Community Spouse Allowance (CSA) that Betty and Alfred are entitled to retain will be adjusted based on his new monthly income.

8. RESPONSIBILITIES OF LONG-TERM CARE PROVIDERS AND THE ECONOMIC SECURITY ADMINISTRATION (ESA)

The institutional care provider or case management agency, in the case of an HCBS Waiver participant, is responsible for helping the institutionalized or HCBS waiver individual or the

individual's family to apply for assistance under Medicaid to pay for the cost of care. The nursing facility or case management agency must assist the individual or the individual's family to obtain any necessary documentation to process their application for Medicaid assistance.

I. PROVIDERS OF INSTITUTIONAL CARE SERVICES

Start of Care Packet - Institutional care providers are required to submit a start of care packet to ESA within seven (7) days of when a long-term care recipient in a nursing facility or ICF/IID can qualify to receive Medicaid long-term care services. The long term care packet consists of the Long Term Care Application and Patient Start of Care Form 1346. For individuals who are not already enrolled in Medicaid, the institutional provider must also submit a Combined Application for Benefits and Level of Care form.

A. **Long Term Care Application** - The long-term care facility is responsible for submitting a completed Long Term Care Application within seven (7) days of when the facility admits an individual who is already enrolled in Medicaid or the individual can qualify to receive Medicaid long-term care services. The Long Term Care Application must be signed and dated by the individual or the individual's authorized representative with proof of D.C. residency. The individual may also be required to submit proof of income, assets, health insurance, and spousal/dependent information.

B. **Combined Application for Benefits** - If the individual is not already enrolled in Medicaid, the long-term care facility is required to submit a completed Combined Application for Benefits in addition to the Long Term Care Application within seven (7) days of when the facility admits the individual or the individual can qualify to receive Medicaid long-term care services. The Combined Application must be signed and dated by the individual or the individual's authorized representative with proof of D.C. residency. The individual may also be required to submit proof of income, assets, health insurance, and spousal/dependent information.

C. **Patient Start of Care Form 1346** - The long-term care facility is required to submit a Patient Start of Care Form 1346 within seven (7) days of when the facility admits an individual who is already enrolled in Medicaid or the individual can qualify to receive Medicaid long-term care services. The completed Patient Start of Care Form must be signed and dated by the long-term care facility Administrator to be processed for long-term care coverage.

All sections must be completed by the facility:

Section A- Patient

The following must be completed;

1. Name

2. Medicaid Number, if available
3. Birth Date
4. Sex: Male or Female
5. Date Admitted to Facility
6. Admitted From: Hospital or Nursing Facility or Residence/Home
7. Name and address from which Admitted

Section B- Medical Condition

The following must be completed;

1. Type of Care Required: Nursing Facility or Skilled Nursing Care
2. Is the Physician's Certificate for Skilled Nursing on file? If "Yes"; what is the period under which the individual is covered under skilled nursing care?
3. Is the Physician's Certificate for Nursing Facility Care on file? If "Yes"; what is the period under which the individual is covered under nursing facility care?
4. Name of Attending Physician, must print or type

Section C - Medicare Information

The following must be completed;

1. Was the Patient admitted into a hospital or skilled nursing facility in the past sixty (60) days? If "Yes"; Name of the Hospital or Skilled Nursing Facility and dates of admission and discharge
2. Is Patient a Medicare Part A Beneficiary? If "No"; Why not? If "Yes"; what are the dates of coverage by Medicare, 100% Medicare coverage and 80% Medicare coverage?
3. What is the Patient Payability Start Date (the date on or after the first day that Medicare Part A coverage ended)?

Section D - Guardian, Conservator, or Authorized Representative

The following must be completed;

1. Name
2. Telephone Number
3. Address
4. Relationship

Section E - Facility

The following must be completed;

1. Name
2. Address
3. Facility Provider Number
4. Administrator Telephone Number
5. Name of Administrator

6. Signature of Administrator and Date form signed

How to Submit Forms to ESA: Completed forms must be sent to:

The Economic Security Administration (ESA)
Long Term Care Unit
609 H St. NE, 5th Floor
Washington, DC 20002

II. PROVIDERS OF HCBS WAIVER SERVICES

A. **EPD Waiver Application Package** - The EPD Waiver case management agency is required to submit an EPD Waiver application package in the CaseNet system when the case manager receives a completed application package for Waiver services. If additional information is needed to complete the eligibility determination process, ESA will contact the individual to obtain the information.

The EPD Waiver application package consists of the following forms:

1. Long Term Care Application
2. 30-AW
3. Risk Assessment
4. Bill of Rights
5. Beneficiary Freedom of Choice
6. Referral for Medicaid Level of Care (this form must be signed by the physician and submitted to the Quality Improvement Organization (QIO) or DHCF designated agent. The Quality Improvement Organization (QIO) or DHCF designated agent will make a determination regarding the level care or functional limitations which places the recipient at risk for institutional care)
7. Health History
8. Individual Service Plan
9. Combined Application for Benefits, if the individual is not already enrolled in Medicaid. The Combined Application must be signed and dated by the individual or the individual's authorized representative with proof of D.C. residency. The individual may also be required to submit proof of income, assets, health insurance, and spousal/dependent information.

B. **IDD Waiver Application Package** – The DDS/DDA Medicaid Waiver Unit is required to submit an IDD Waiver application package to ESA when the DDS/DDA Medicaid Waiver Unit receives a completed application package for Waiver services. If additional information is needed to complete the eligibility determination process, ESA will contact the DDS/DDA Medicaid Waiver Unit to obtain the information.

III. ECONOMIC SECURITY ADMINISTRATION (ESA)

The ESA Long Term Care Eligibility Unit is responsible for processing community Medicaid applications, long term care applications, and HCBS Waiver applications.

An individual who is determined eligible for or is already enrolled in Medicaid must also have eligibility for long-term care services determined by the ESA Long Term Care Eligibility Unit at the time of institutionalization or start of HCBS Waiver services.

For institutionalized individuals, when the ESA Long Term Care Eligibility Unit determines that an individual is eligible for Medicaid long-term care services, it will calculate the beneficiary contribution to cost of care and issue an eligibility notice to the long-term care facility and the individual.

For EPD Waiver participants, ESA will process the Waiver application package after it is submitted in the CaseNet system and notify the DHCF Long Term Care Eligibility Unit of the eligibility determination.

For IDD Waiver participants, ESA will process the Waiver application package after it is submitted to ESA and notify the DDS/DDA Medicaid Waiver Unit of the eligibility determination. All notices and other information relating to an individual's Medicaid eligibility are mailed to the DDS/DDA Medicaid Waiver Unit.

8. RESPONSIBILITY

The Department of Human Services, Economic Security Administration (ESA) and Department of Health Care Finance (DHCF) are responsible for the implementation of this policy and procedure.

Claudia Schlosberg, J.D.
Acting Senior Deputy Director

Date

ATTACHMENT A – INCOME

Countable Income:[18]

- Earned Income-taxable income received from working (wages, salaries, tips, union strike benefits);
- Unearned Income- any income received from other sources other than employment (Social Security Income, VA, Private Pensions, SSI, Railroad Retirement, Civil Service Retirement, interest, dividends, investments, income from rental property)
- Self-Employment

Non-Countable Income:[19]

- Children's Earnings (earnings from an unmarried child who is living with a person who provides care or supervision);
- Adoption Subsidy;
- AmeriCorps/VISTA Income;
- Child Nutrition Payments;
- Domestic Volunteer Service Act Payments;
- Earned Income Taxes Credit;
- Educational Benefits (e.g., Department of Education (DOE) Bureau of Indian Affairs Benefits, DOE Title IV Benefits, DOE Perkins Vocational and Applied Technology Education Act, DOE work study wages and other Education benefits work study);
- Energy Assistance;
- Foster Care Payments;
- Housing Assistance provided by the federal or District of Columbia government or non-profit organizations;
- Incentive Payments for Prenatal & Well-Baby Care and from the Work Incentive programs for current or former TANF recipients;
- In-Kind Benefits- non-cash benefits in the form of voucher, commodity or service (food stamps, Section 8 voucher);
- Jury Duty Payments
- Money Received By a Third Party for a Group Member (not counted unless group member gains access to the funds);
- Money Received by Group Member on Behalf of Non-Group Member (not counted as income received if it does not reflect the needs of the person receiving the money);
- Nutrition Payments;
- Rehabilitation Service Administration Payments;
- Reimbursements;
- Roommates- Shared Living Arrangement;
- Senior Community Service Employment;
- TANF Underpayments;
- Training Income: Training Expense Allowances/Stipends; and
- Utility Allowances Received Through a Housing Program.

[18] Medicaid State Plan, Supplement 8a to Attachment 2.6-A.
[19] Id.

ATTACHMENT B – ASSETS

Exempt Assets:[20]

- Personal home (if the individual's home equity interest does not exceed the maximum home equity limit);[21]
- Accounts Receivable;
- Burial Funds (if the funds are in a separate; designated account);
- Promissory Notes (if the notes are not related to transfers of assets within the past 36 months);
- Earned Income Tax Credit (excluding for the first 12 months);
- Energy Assistance (if the payments are co-mingled with other countable assets, then the agency will apply SSI operational methodologies);
- Proceeds from Home Sale (if the customer purchases or intends to purchase new home within the next 12 months);
- Household/Personal Goods;
- Inaccessible Assets (assets that are not legally available that have a value that is not able to be sold for a reasonable return);
- Indian Lands;
- Jointly Owned Assets (if the owner is legally unable to liquidate asset);
- Land Contract;
- Life insurance (if the face value is under $1,500);
- Life Insurance Funded Funerals;
- Loan-Related Assets;
- Non-Saleable Assets (not fit to sell or capable of being sold);
- Property Pending Sale;
- HUD Reimbursements;
- Vehicles (limited to one per household);
- Higher Education Savings Plans (including 529 accounts, education IRAs, etc.);
- U.S. Savings Bonds (if penalties apply to early withdrawals/liquidations and they have not been renewed /reinvested during any immediately preceding period of Medicaid eligibility);
- Individual Retirement Accounts (IRAs, which include Roth and other non-educational IRAs);
- Keogh Accounts (a tax deferred trust saving account that allows self-employed individuals or those who own their own incorporated business to save for their retirement);
- Other Retirement Accounts (including 401(k), 403(b), and 457 accounts but excluding some types of annuities (if these payments are co-mingled with other countable assets, then the agency will apply SSI operational methodologies); and
- Funds or deposits with Continuing Care Retirement Communities (unless the funds can be used to pay for care under the terms of the contract should other resources of the individual be insufficient; the entrance fee, or remaining portion, is refundable when the individual dies or leaves the community; and the fee confers no ownership interest in the community).

[20] Medicaid State Plan, Supplement 8b to Attachment 2.6-A.

[21] The Centers for Medicaid and Medicare Services (CMS) sets the maximum home equity limit annually. The maximum home equity limit does not apply if the spouse of the individual or a child of the individual who is under age 21 or has a disability resides in the home.

ATTACHMENT C – INCURRED AND RECURRING MEDICAL EXPENSES

Incurred medical expenses are medical expenses incurred by an individual, family member, or financially responsible relative that are not subject to payment by a third party (e.g. insurance provider). This may include premiums, deductibles, copayments, enrollment fees, and expenses for necessary medical and remedial services.[22] Recurring medical expenses are expenses that an institutionalized individual is projected to incur within the spend down budget period. Only medical expenses related to institutional care may be projected. Recurring medical expenses that are not subject to payment by a third party may be counted at the Medicaid reimbursement rate. For individuals enrolled in an HCBS Waiver, only medical expenses for care that is equivalent to an institutional level of care may be counted as a projected institutional expense.

For the purposes of calculating an individual's initial spend down obligation, deduct all incurred expenses that an individual incurs before application, regardless of the date of the service, if the expense has not already been used in another budget period, if the individual is still liable for them, or if the individual has paid for them in the current budget period.[23]

[22] 42 CFR §435.831(d) and (e)
[23] 42 CFR §435.831(f)

ATTACHMENT D – TREATMENT OF TRUSTS, ANNUITIES, AND CERTAIN FINANCIAL TRANSACTIONS

A. Revocable Trust

In the case of a revocable trust:

- The entire corpus of the trust is counted as an available resource to the individual;
- Any payments from the trust made to or for the benefit of the individual are counted as income to the individual;
- Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value.

B. Irrevocable Trust

In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply to that portion:

- Payments from income or from the corpus made to or for the benefit of the individual are treated as income to the individual;
- Income on the corpus of the trust which could be paid to or for the benefit of the individual is treated as a resource available to the individual;
- The portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual; and
- Payments from income or from the corpus that are made but not to or for the benefit of the individual are treated as a transfer of assets for less than fair market value.

When all or a portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets for less than fair market value. In treating these portions as a transfer of assets, the date of the transfer is considered to be:

- The date the trust was established; or,
- If later, the date on which payment to the individual was foreclosed.

In treating portions of a trust which cannot be paid to an individual, the value of the transferred amount is no less than its value on the date the trust is established or payment is foreclosed. When additional funds are added to this portion of the trust, those funds are treated as a new transfer of assets for less than fair market value.

C. Exceptions to Treatment of Trusts:

Establishment of the following trust types do not constitute a transfer of assets for less than fair market value:

- **Special Needs Trust** - a trust containing the assets of an individual under age 65 with a disability and which is established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court. The trust must contain a provision stating that, upon the death of the individual, the District receives all amounts remaining in the trust, up to an amount

equal to the total amount of medical assistance paid on behalf of the individual under the Medicaid State Plan. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the individual with a disability.

- **Pooled Trust** – containing the assets of an individual with a disability that meets the following conditions:
    - The trust is established and managed by a non-profit association;
    - A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;
    - Accounts in the trust are established solely for the benefit of individuals with a disability by the individual, by the parent, grandparent, legal guardian of the individual, or by a court; and
    - To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the District the amount remaining in the account up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the Medicaid State Plan. To meet this requirement, the trust must include a provision specifically providing for such payment.

D. Annuities

At the time of application, applicants must disclose any interest in an annuity. For annuities purchased on or after February 8, 2006, the annuity must name the District as the primary remainder beneficiary, or second remainder beneficiary after a community spouse or minor or child with a disability, for an amount equal to the total amount of medical assistance paid on behalf of the individual under the Medicaid State Plan. The annuity must be irrevocable, non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity, with no deferral or balloon payments; or meet the requirements pertaining to retirement plans identified in 42 U.S.C. 1396p(c)(1)(G)(i). If the annuity does not meet these requirements, the full purchase price of the annuity is the amount considered a transfer for less than fair market value.

For annuities purchased prior to February 8, 2006, actions taken by the individual that change the course of payments to be made by the annuity or treatment of the income or principle of the annuity subject the annuity to the requirements related to transfers of assets for less than fair market value. Routine changes and automatic events that do not require action by the individual do not subject the annuity to the requirements related to transfers of assets for less than fair market value.

E. Life Estates

The purchase of a life estate interest in another individual's home is treated as a transfer of assets for less than fair market value, unless the purchaser lives in the home for at least one year after the date of purchase. If the purchase the purchase amount of the life estate is greater than the computed value of the life estate's interest, the difference is considered a transfer for less than fair market value.

F. Promissory Notes and Loans

The purchase of a promissory note, loan, or mortgage is treated as a transfer of assets for less than fair market value unless the following conditions are met:

- The repayment terms are actuarially sound;
- Payments are made in equal amounts with no balloon payments; and
- The note, loan, or mortgage prohibits cancellation of the debt upon the death of the lender.